

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

1. PLACE OF DEATH

County.....
Township.....
City St. Louis (No. Isolation Hosp)

Registration District No. 791
Primary Registration District No. 1003

File No. 22019
Registered No. 5770 Ward.....

2. FULL NAME

(a) Residence, No. 32 & 4 W. 16th St., 16 Ward.

(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 14, 1930

7. AGE YEARS 4 MONTHS 0 DAYS 25 If LESS than 1 day, hrs. or min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Nil
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis Mo

13. NAME John Mc Cullough

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis Missouri

15. MAIDEN NAME Catherine Hennerich

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Memphis Tenn

17. INFORMANT Grace Garry (ADDRESS) 3600 Osceola

18. BURIAL, CREMATION, OR REMOVAL

PLACE Calvary DATE June 11, 1934

19. UNDERTAKER Oscar J. Hoffmeister (ADDRESS) 1016 1/2 N. 10th St.

20. FILED 10-15-34 19 10-15-34

3 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 9, 1934

22. I HEREBY CERTIFY that I attended deceased from June 7, 1934 to June 9, 1934

Last saw him alive on June 9, 1934 Death is said to have occurred on the date stated above, at 5:00 a.m.

The principal cause of death and related causes of importance were as follows:

Pertussis 9 Date of onset

Bronchopneumonia

Other contributory causes of importance:

Toxic Encephalitis

Name of operation None Date of

What test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide No Date of injury....., 19.....

Where did injury occur? No (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?

If so, specify John Eichenbream M. D.

(Signed) John Eichenbream (Address) ISOLATION HOSPITAL

Registrar.

N. B. - Every item on this certificate is equally important. Exact statement of OCCUPATION is very important.

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**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County.....

Registration District No. 791

File No.

Township.....

Primary Registration District No. 1003

Registered No. 5770

City.....

(No. Isolation Hosp)

St.

Ward.....

2. FULL NAME

(a) Residence, No.

St.

Ward.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

m

4. COLOR OR RACE

w

5. SINGLE, MARRIED, WIDOWED, OR
DIVORCED (write the word)

married

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1
day, hrs.
or min.

4

0

25

OCCUPATION

8. Trade, profession, or particular
kind of work done, as spinner,
sawyer, bookkeeper, etc.

9. Industry or business in which
work was done, as silk mill,
saw mill, bank, etc.

10. Date deceased last worked at
this occupation (month and
year)

11. Total time (years)
spent in this
occupation

12. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

FATHER

13. NAME

14. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

MOTHER

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

17. INFORMANT
(ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE

DATE

19

19. UNDERTAKER
(ADDRESS)

20. FILED

9-1-34

J. F. Bredeck

Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR)

June 9, 1934

22. I HEREBY CERTIFY, That I attended deceased from

....., to....., 19.....

I last saw h..... alive on....., 19..... Death is said

to have occurred on the date stated above, at..... m.

The principal cause of death and related causes of importance were as follows:

Pertussis

Broncho pneumonia

Not epidemic

Other contributory causes of importance:

Acute myocardial infarction

Not epidemic

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?.....

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?

If so, specify.....

(Signed) H. Schenbrenner, M.D.

(Address).....

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD
CAUSE OF DEATH TO BE WRITTEN IN PLAIN, UNFADING INK--THIS IS A PERMANENT RECORD

REGISTRARS SHALL NOT RECEIVE A FEE FOR THIS SERVICE

5-22019